

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2014
FORM APPROVED
OMB NO. 0938-0391

45th 4/12/14

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445159 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 02/26/2014 |
| NAME OF PROVIDER OR SUPPLIER BETHANY HEALTH CARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 421 OCALA DRIVE NASHVILLE, TN 37211 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 000 | INITIAL COMMENTS | F 000 | | | |
| F 281 SS=D | <p>A recertification survey and complaint investigation # 32739, were completed on February 26, 2014, at Bethany Health Care Center. No deficiencies were cited related to the complaint under 42 CFR Part 483.13, Requirements For Long Term Care.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide the necessary assistance and supervision needed during a meal for one resident (#41) of thirty-four residents reviewed.</p> <p>The findings included:</p> <p>Medical record review revealed resident #41 was admitted to the facility on May 31, 2007, and readmitted on November 16, 2012, with diagnoses including Failure to Thrive, Dysphagia, Senile Delusion, Diaphragmatic Hernia, Gastroesophageal Reflux Disease, Coronary Artery Disease, and Intestinal Disorder.</p> <p>Medical record review of a physician's recapitulation orders dated February 1-28, 2014, revealed, "...DIET: MECHANICAL SOFT..."</p> <p>Medical record review of a quarterly Minimum Data Set (MDS) dated January 8, 2014, revealed</p> | F 281 | <p>Resident # 41 was examined by the NP after she was assisted to her room to lie down on 2/25/14. Diagnostics were ordered and completed on 2/25/14 including a Chest X-Ray, Urinalysis and Laboratory tests. Chest X-Ray was negative. Urinalysis was positive for Leukocytes and Nitrites and was forwarded to the lab for Culture and Sensitivity. Antibiotic therapy was initiated for UTI. Medications were reviewed by the NP and drugs with sedating effects were held until the Resident's mental status returned to baseline on 2/25/14. Resident #41 has had no further episodes of lethargy. (See attachment #1).</p> <p>Reviewed medical record for Resident #41 including post hospitalization Speech Therapy evaluation of 11/19/12. NP authorized correction to diagnosis list on 2/27/14; Dysphagia changed from an active diagnosis to a historical diagnosis. (See attachment #2 and #3).</p> | 04/04/2014 | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Laura Harris

NHA

3/19/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 281 | <p>Continued From page 1</p> <p>the resident scored a nine on the Brief Interview for Mental Status (BIMS), indicating the resident was moderately cognitively impaired. Continued review revealed the resident required supervision for eating.</p> <p>Medical record review of a care plan last revised February 20, 2014, revealed "...Swallowing/Aspiration...nurse aide...assist resident with meals as needed...Encourage resident to remain upright as tolerated during meal..."</p> <p>Observation on February 25, 2014, at 8:10 a.m., in the second floor dining room, revealed resident #41 was asleep with the resident's head lying on the table beside the resident's breakfast tray. Continued observation at 8:18 a.m., revealed Certified Nursing Technician (CNT) #1 woke the resident up and told the resident "you need to eat." CNT #1 then walked away from the table. Resident #41 tore off a piece of toast, placed it in the resident's mouth, and without chewing or swallowing laid his/her head back down on the table and went to sleep. Further observation at 8:21 a.m., revealed CNT #1 awoke the resident and said "you have fallen asleep with toast in your mouth, wake up." The resident raised his/her head and CNT #1 walked away. The resident laid his/her head back on table beside the breakfast tray and fell asleep with the toast still in the mouth. Further observation at 8:25 a.m., revealed CNT #1 approached the resident and said "wake up and let's eat your breakfast, do you want me to help you...wake up and eat your breakfast, then you can go lay down." Resident #41 ate the peice of toast he/she placed in the mouth at 8:18 a.m. (seven minutes earlier). CNT #1 then fed resident #41 one bite of oatmeal.</p> | F 281 | <p>Observations for signs of lethargy were made of all other Residents while dining on 2/25/14 and 2/26/14. No other Residents were identified.</p> <p>Nursing Staff, including Licensed Nurses and Certified Nurse Technicians, Restorative Staff and Paid Feeding Assistants were given In-service Education regarding standards of practice for Resident Dining, Supervision and Assistance with Meals. In-services to be completed by 3/31/14. (See attachment #4).</p> <p>QAPI Committee held a special meeting on 3/14/14 for the purpose of review and approval of the Plan of Correction including review of standards for Resident Dining, Supervision and Assistance with Meals, plan for staff education, and method for monitoring to ensure compliance. Plan of Correction and components approved. Membership of the QAPI Committee includes the Administrator, Medical Director, DON and Department Managers. (See attachment #5 and #6).</p> | |
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| F 281 | <p>Continued From page 2</p> <p>Continued observation revealed the resident held the oatmeal in the mouth. CNT #1 asked the resident "are you going to eat or do you want to go lay down." The resident did not respond. Further observation at 8:32 a.m., revealed CNT #1 removed the resident from the dining room.</p> <p>Interview on February 25, 2014, at 8:45 a.m., with CNT #1, in the second floor dining room, revealed the resident was asleep at the table in the dining room with food in the mouth, "this isn't normal for (the resident)."</p> <p>Interview on February 25, 2014, at 12:40 p.m., with the Director of Nursing (DON) in the conference room, confirmed would not expect staff to continue to feed a sleeping resident, and the resident did not receive the assistance and supervision needed during the meal.</p> | F 281 | <p>The Clinical Coordinator and/or Assistant, Nurse Supervisors and/or Department Heads will conduct Dining Observations using the Dining Observation Tool on a weekly basis for 3 weeks beginning with the week of 3/10/14. Observations will be made in the First and Second Floor Day Rooms and the Dining Room during at least two meals per week in each location. (See attachment #7).</p> <p>Dining Observation results will be compiled by the Clinical Coordinator and reported to the Administrator, the DON and the QAPI Committee at the quarterly meeting scheduled for 3/31/14. The frequency of monitoring following the 3/31/14 report will be determined by the QAPI Committee.</p> | | |